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Commentary

The need to revise pain diagnoses in ICD-11 ☆

An adequate reflection of pain diagnoses in the upcoming ICD-11 is crucial for the necessary improvements in the management of patients with pain, but also for facilitating the launch of research programs for specific diagnosable pain conditions. Some health care systems completely depend on diagnoses (e.g., "diagnosis related group systems" DRG), and adequate pain treatment (e.g., interdisciplinary approaches) can only be provided if this need is reflected in diagnoses. ICD-10 included many pain diagnoses (see Table 1), but they are somewhat arbitrarily distributed over several categories, and sometimes poorly defined. Several chronic pain conditions are badly represented and a serious revision of the pain diagnoses of ICD-10 is at stake. For the ICD-11 revision process, topical advisory groups and work groups have been implemented by WHO (e.g., on "Internal Medicine", "Mental Health", "Eye Diseases"), but to date no expert committee on pain is yet involved.

During the past years, many research results and activities of the IASP and other societies led to proposals that should be addressed in the revision process of ICD-11. A few examples of how these comprehensive proposals can be transformed into ICD-11 diagnoses will be outlined. This transformation has to consider both pain expertise and ICD construction rules (e.g., feasibility in routine clinical care and in different medical specializations; clear and scientifically well-founded criteria; applicable both in developed and developing countries). Therefore the new classification system must not overspecialize, and be practical by its simplicity. Different diagnoses should reflect different clinical entities.

Table 1
Examples of pain diagnoses in ICD-10.

- Migraine (G43), other headaches (tension-type headache, cluster headache, vasomotor headache G44)
- Trigeminal neuralgia, atypical facial pain (G5)
- Phantom pain (G54)
- Neuropathic pain (several G-diagnoses and others)
- Dental pain (K08)
- Back pain (M54)
- Fibromyalgia (M79.4)

F-diagnoses (psychiatric diagnoses):

- Persistent somatoform pain disorder (F45.4)
- Chronic pain disorder with somatic and psychological factors (F45.41 German Edition)
- Enduring personality change due to chronic pain (F62.8)

R-diagnoses: symptoms, not otherwise specified (NOS):

- Chest pain, NCCP, precordial chest pain R07
- Abdominal pain, pelvic pain R10
- Pain while urinating R30.9
- Headache NOS R51
- Pain, not elsewhere specified R52

To classify headache, a selection of the suggested diagnoses [3] should be included in ICD-11: the revised criteria for migraine, differentiating episodic and chronic migraine; the revised criteria for tension-type headache, again differentiating episodic and chronic subtypes; cluster headaches and other trigeminal autonomic cephalalgias; medication overuse headache, headaches and neck pains attributed to head and neck traumas and cranial neuralgias. For back pain some classification principles are at least questionable (e.g., the classification of fibromyalgia as a "soft tissue disorder"), while others are poorly defined (e.g., low back pain). It is suggested that acute versus chronic subtypes should be differentiated, as well as different types of severity. Further classification attempts for back pain should be considered [1]. A re-definition and a grading system for clinical and research purposes of neuropathic pain has been suggested [9]. This re-definition is closely linked to neurological diseases and their diagnosis. The important field of cancer pain is poorly reflected in ICD-10, and needs substantial revision [5]. Cognitive and behavioral processes have shown to be active in a variety of chronic pain conditions, including pain with and without a clear somatic pathology. These psychological features should be diagnosed if they are relevant for treatment planning. In this context, the German version of ICD-10 introduced a new diagnosis of "chronic pain disorder with somatic and psychological factors" in 2009 [7,8], but also a transdiagnostic approach might be considered (e.g., [2,4]). Finally, as an alternative to the classic, syndromal approach of a classification system, patients can also be described along dimensions of functioning. As pain is only loosely associated with daily functioning, and experienced problems with the latter are an important drive to seek help, the provision of dimensional scales of functioning may improve the clinical utility of the classification system (e.g., [6]).

With this editorial, we strongly encourage the membership and chapters of IASP as well as other pain societies to contribute to the revision process by identifying problematic points and suggesting improvements. Therefore IASP will open a discussion forum on its webpage (www.iasp-pain.org) to facilitate the discussion and revision process. Moreover, an improvement of the interaction with the World Health Organization is necessary. The improvement of the classification of chronic pain is a major precondition for the amelioration of medical care and interdisciplinary management of patients with chronic pain conditions, as well as for the improvement of research programs addressing pain in all its facets.

☆ IASP has established an online discussion forum for IASP members to discuss the ICD-11 update. If you want to participate, please register for the e-forum at www.iasp-pain.org/forums.

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Conflict of interest

None of the authors declares conflicts of interests that influenced the content expressed in this commentary.

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